Merging the Individual, Small-Group, and Association Markets in Vermont

prepared for

Vermont Health Care Reform Commission

prepared by

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Health Management Associates is an independent national research and consulting firm specializing in complex health care program and policy issues. Founded in 1985, in Lansing, Michigan, Health Management Associates provides leadership, experience, and technical expertise to local, state, and federal governmental agencies, regional and national foundations, investors, multi-state health system organizations, and single-site health care providers, as well as employers and other purchasers in the public and private sectors. HMA has ten offices strategically located throughout the United States.

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Executive Summary

The purpose of this study is to examine the issues Vermont would need to address if it were to merge the individual, small-group, and association health insurance markets to create a single market—and single risk pool for each insurer. In a merged market, each insurer would have only one "community" or pool, and the community rate would apply to everyone in the community. People buying a particular benefit package from a particular insurer—whether as an individual, an independent small employer, or as a member of an association—would all pay the same premium.

The individual and small-employer markets in Vermont suffered major declines between 2000 and 2007. The small-group (non-association) market lost 58 percent of enrollment, falling to about 20,000 lives, and the individual market saw a 44 percent decline, to about 9,000 lives. These enrollment drops were partially offset by a 29 percent enrollment growth in association plans, which had an enrollment of nearly 96,000 in 2007. These precipitous changes suggest that these insurance markets are not functioning well to serve all those who depend on them for coverage, particularly people left in the individual and small-group markets, who are almost certainly paying more for coverage.

A merger of markets could reasonably be expected to achieve certain desirable objectives. It would probably make coverage more affordable for people who now pay above-average premiums, especially those in the individual and small-group markets, but at the cost of some increase in premiums for others, particularly for some associations that now enjoy below-average premiums. A merger would give those now in the individual market a broader range of coverage choices, and it would probably reduce the year-to-year volatility in prices for some buyers of insurance. Individuals, as well as small businesses that now cannot find an appropriate association plan, would be better served. A merged market, however, would probably not lower average premiums appreciably, and the number of uninsured would probably not be much affected.

A merger of markets would be disruptive if it caused large increases in prices for some people buying insurance. Because Vermont already requires insurers to offer coverage to all who apply and to community rate, a merger would be less disruptive than in most states, where coverage is not available on a guaranteed-issue basis in the individual market and where rates vary widely based on the risk profile of the individual or group being insured. In such states, a merger would likely cause severe adverse selection—because of an influx of high-risk people when the market is opened

up—causing premiums to rise. But the market in Vermont has already absorbed such adverse selection. In fact, if prices were to decline for individual coverage, as is likely, more *low-risk* people would be likely to acquire insurance.

The extent of premium changes, and thus the disruptive effects, depend on the relative numbers of people in each market and the degree to which prices in those markets differ. If just a small proportion of people are paying high premiums, merging them with others will cause only a small price increases for everyone else. The same is true if price variations are small from market to market. People in the individual and small-group non-association market are probably now paying significantly more for coverage than those in association plans. And some association plans enjoy lower premiums than others. But because the individual and small-group markets are relatively small compared to the association market, and because the price differentials, though significant, appear not to be extreme between markets and among associations, a merger would probably not cause a large premium increase for most associations and would produce some savings for individuals and some small employers. But it is important to remember that the greater the savings to some, the greater the premium increase for others. Conversely, the less the savings, the weaker the case for a merger.

The individual and small-employer markets consist of numerous risk pools: each association plan, the small-group market, the Blue Cross Blue Shield (BCBSVT) individual market, the for-profit individual market, the BCBSVT Safety Net market, and Catamount Health. An important issue is which of these should be included in a merged risk pool. If a merger is to have a significant effect in improving the performance of the markets now experiencing problems, it makes sense to merge most, if not all, of the risk pools into a single pool. Achieving horizontal equity—equal treatment of people in equal circumstances—also argues for merging all the pools. One exception could be Catamount Health, which is a subsidized program designed for a particular population; but even this program could be merged with others, if certain elements unique to the program were retained.

Several issues arise in implementing a merger, including how to ensure that everyone has access to a variety of product offerings and that insurers do not "game" the system to attract a favorable selection of risks. If there is concern that a merger might cause sudden rate increases for some that would cause hardships, the effects might be mitigated by phasing in the merger over perhaps three years. Alternatively, the state could consider allowing some modest degree of age rating instead of imposing "pure" community rating across the board. Age rating would probably moderate the extent of premium increases for those associations that now enjoy a premium advantage.

Merging the Individual, Small-Group, and Association Markets in Vermont

Study Objectives

The purpose of this study is to examine the issues Vermont would need to address if it were to merge the individual, small-group, and association health insurance markets to create a single market that would serve all people buying as individuals or as members of a small-employer group. The expected result would be that a person covered by a particular set of benefits with a specific insurer would pay the same premium, regardless of whether he or she is covered as an individual or as a worker in a small group (defined as a group of 50 or fewer employees). Assuming community rating remains in force, the premium of anyone in each insurers' risk pool would be determined by dividing the total expected costs for everyone in the pool by the number of people in the pool (with adjustments for differences in the actuarial value of different benefit packages).[1]

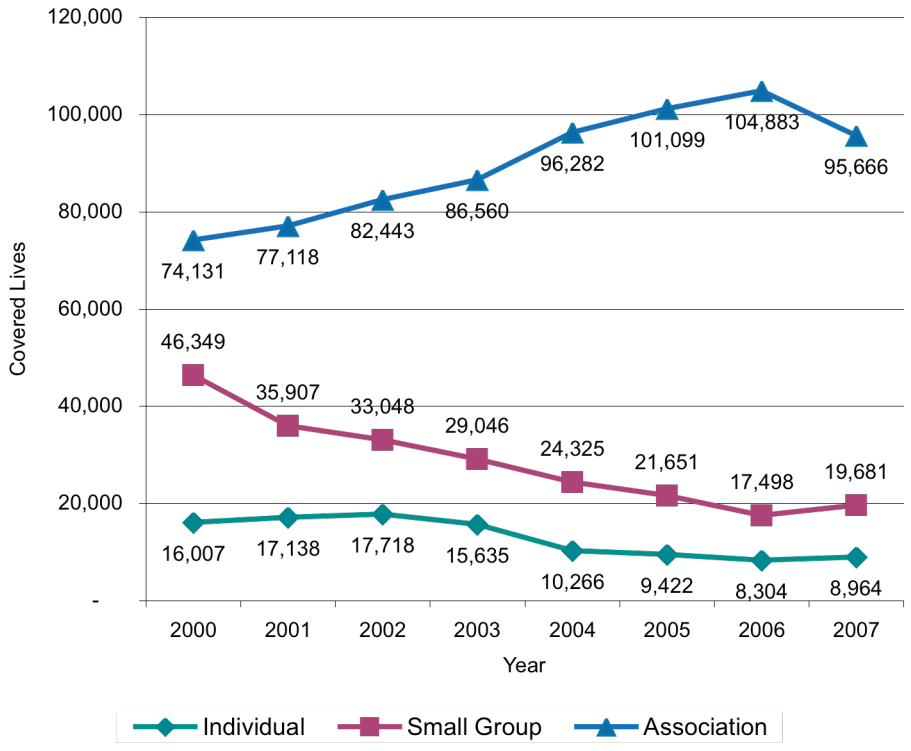
What such a policy would accomplish would be to extend the principle of community rating beyond its present application by creating one single risk pool per insurer rather than maintaining the present system of multiple pools. Under current insurance rules, individuals are in one pool, employers buying small-group coverage are in another, and employers buying association plans are each in a separate risk pool made up of just the persons covered by their association. Thus, people in the individual market, the small-group market, and each association now all pay different rates even when coverage is identical. In a merged market, each insurer would have only one "community" or pool, and the community rate would apply to everyone that the insurer covers.

[1]This is a slight overstatement. There would presumably still be a community rate for single coverage and a community rate for family coverage. Moreover, if some benefit plans include cost-containment measures that produce savings not present in other benefit plans or providers are paid different rates than in other plans, premium variations that reflect these source of savings would presumably still be permitted.

PERFORMANCE OF THE INDIVIDUAL AND SMALL-EMPLOYER MARKETS

It is useful to start the analysis by looking at the recent performance of the three markets. As shown in Figure 1, the association market is by far the largest of the three markets, insuring almost 96,000 people. The small-group market[2] covers almost 20,000, and the individual market only about 9,000. Looking at the experience of the three markets over the period from 2000 to 2007 shows very different enrollment trends (Figures 1 and 2). The small-group (non-association) market fared the worst, experiencing a drop in covered lives of almost 27,000, or 58 percent, during the period. In part, this was almost certainly a result of many small employers switching to association plans, which gained more than 21,000 lives, for a 29 percent enrollment growth. The individual market experienced a major decline: enrollment fell by 44 percent, equal to a loss of over 7,000 covered lives.[3] Enrollment in the three groups combined fell by over 12,000, or about 9 percent.

FIGURE 1. COVERED LIVES INDIVIDUAL, SMALL-GROUP, AND ASSOCIATION MARKETS, VERMONT, 2000-2007



[2] In this report we use the term "small-group market" to refer to the portion of the market serving small employers who are not in association plans. The term "small-employer market" includes both the small-group market and the association plan market.

[3] Data for the individual market includes Catamount Health enrollment.

Enrollment in *large* insured groups also fell significantly during the 2000 to 2007 period. The number of covered lives in large insured plans declined by more than 28,000, or about 26 percent (Figure 2). However, as Figure 3 shows, the decreases in enrollment in the individual, small-employer, and large-group plans was offset somewhat by increased coverage in insurance provided to Vermont residents by out-of-state insurers. When this coverage plus coverage from self-insured employers is accounted for, the number of total covered lives fell by about 1 percent between 2001 and 2007.

The various markets are also very concentrated, with just four firms accounting for nearly all of the business, as shown in Figure 4 below.

FIGURE 2: CHANGE IN NUMBER OF COVERED LIVES, INDIVIDUAL, SMALL-GROUP, AND LARGE-GROUP COVERAGE, VERMONT, 2000-2007

Type of Plan	Enrollment 2007	Change 2000-2007	% Change 2000-2007
Individual	8,964	(7,043)	-44.0%
Small Group	19,681	(26,668)	-57.5%
Association	95,666	21,535	29.0%
Total Individual & Small Group	124,311	(12,176)	-8.9%
Large Groups+ Other	78,490	(28,102)	-26.4%
Total All Insured Plans	202,801	(40,278)	-16.6%

Source: *2007 Annual Statement Supplement Report, Department of Banking, Insurance, Securities and Health Care Administration.*

FIGURE 3. TOTAL COVERED LIVES ALL PRIVATE INSURANCE, VERMONT, 2000-2007

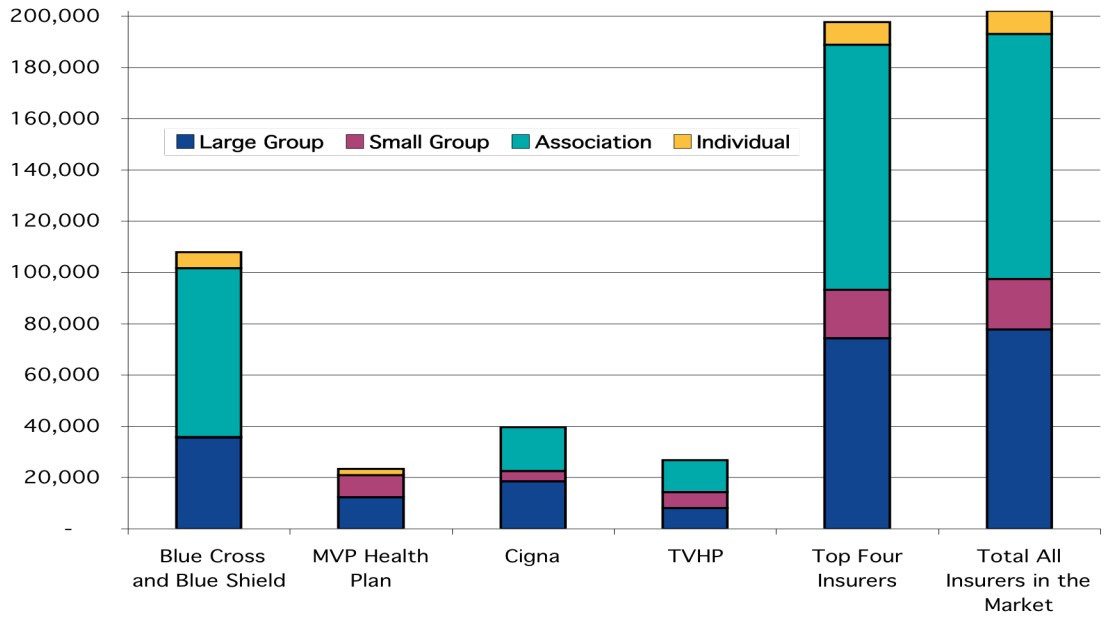
	2000	2001	2002	2003	2004	2005	2006	2007
Individual	16,007	17,138	17,718	15,635	10,266	9,422	8,304	8,964
Small Employer	46,349	35,907	33,048	29,046	24,325	21,651	17,498	19,681
Association	74,131	77,118	82,443	86,560	96,282	101,099	104,883	95,666
Large Groups	106,584	84,414	76,181	78,753	92,541	83,181	75,657	77,641
Other	8	28	43	18	20	23	41	849
Covered by out-of-state insurers	n/a	42,000	42,000	41,000	41,000	45,715	56,857	55,926
Self-Insured	n/a	105,350	108,005	108,929	93,505	102,006	95,346	97,700
Total Private Insurance Coverage	n/a	361,955	359,438	359,941	357,939	363,097	358,586	356,427

Source: Source: *2007 Annual Statement Supplement Report, Department of Banking, Insurance, Securities and Health Care Administration; Health Insurance Coverage Profile of Vermont Residents, 2001-2006,* Vermont Division of Health Care Administration.

Note: Self-insured enrollment is estimated by the Department of Banking, Insurance, Securities and Health Care Administration.

FIGURE 4. COVERED LIVES, MARKET SHARES FOR LARGE GROUP, SMALL GROUP, ASSOCIATION, AND INDIVIDUAL MARKETS, TOP FOUR INSURERS, VERMONT, 2007.

Insurer	Market	Covered Lives	Market Share
Blue Cross and Blue Shield	Large Group	35,518	45.7%
	Small Group	165	0.8%
	Association	65,827	68.8%
	Individual	6,371	71.1%
MVP Health Plan	Large Group	12,183	15.7%
	Small Group	8,737	44.4%
	Association	-	0.0%
	Individual	2,450	27.3%
Cigna	Large Group	18,413	23.7%
	Small Group	3,983	20.2%
	Association	17,190	18.0%
	Individual	-	0.0%
TVHP	Large Group	8,104	10.4%
	Small Group	6,129	31.1%
	Association	12,502	13.1%
	Individual	-	0.0%
Top Four Insurers	Large Group	74,218	95.6%
	Small Group	19,014	96.6%
	Association	95,519	99.8%
	Indivdiual	8,821	98.4%
Total All Insurers in the Market	Large Group	77,641	100.0%
	Small Group	19,681	100.0%
	Association	95,666	100.0%
	Individual	8,964	100.0%
	Total	201,952	



Source: *2007 Annual Statement Supplement Report, Department of Banking, Insurance, Securities and Health Care Administration; Health Insurance Coverage Profile of Vermont Residents, 2001-2006,* Vermont Division of Health Care Administration.

RATING RULES IN THE THREE MARKETS

As noted earlier, the effect of merging the individual and small-employer markets would be to have a single set of rating rules that would be applicable to anyone seeking coverage as an individual or as part of an employer group. Insurers would charge the same premium for an applicant buying a particular benefit package regardless of whether the person was applying as an individual or as an employee of a small employer and regardless of whether the employer was buying coverage on their own or as a member of an association. Of course, each insurer would set its own rates, so rates would often differ from insurer to insurer even if the benefit packages were similar. But an insurer could not set different rates for different people buying the same benefit package.

To understand the implications of this change it is important to understand how premiums are currently set in the individual, small-group, and association markets.

The Individual Market

The individual market (sometimes called the "non-group market") serves people who are purchasing coverage on their own, often for themselves and their family, rather than through a group. The individual market in Vermont differs from that of nearly all other states because insurers are required to community rate. To put it more accurately, Blue Cross and Blue Shield (BCBSVT) is required to use "pure" community rating—which means that the rate is the same for each person buying a particular benefit package, regardless of the person's age, health status, or any other characteristics that might affect the likelihood of needing medical services. For-profit insurers operating in the individual market are not required to do pure community rating; they are allowed to adjust rates for age by plus or minus 20 percent. Most states allow much larger rate variation and the use of more rating factors in the individual market.

For the most part, the individual market serves primarily people who do not have access to employer-sponsored coverage. The reason is that purchasing coverage in the individual market is a second-best option for most people, for a variety of reasons.

First, employer-sponsored coverage is a better buy—not only because the employer normally pays much of the premium, but also because the employer's contribution is not taxed as income to the employee. If employees had to purchase individual coverage on their own, not only would they be paying the full cost out of pocket, but they would also be using after-tax dollars. For example, if an employer contributes $100 toward the employee's health insurance premium, that buys $100 of coverage. If the employer instead gave that $100 to the employee in the form of higher wages, and the employee then went out to buy individual coverage, that $100 would buy only $70 of coverage for a person whose marginal tax rate is 30 percent. The rest would go to taxes, including federal and state income tax, Social Security tax, and Medicare tax. A person who has to buy individual-market coverage enjoys no tax subsidy, so the after-tax cost is much higher than for the person who has employer coverage.

Second, individual coverage is generally more expensive than equivalent employer-sponsored coverage because insurers' administrative costs associated with marketing and servicing people who buy as individuals are inherently higher than for large groups or even smaller groups. Because of diseconomies of scale, it is more costly to market coverage and provide after-sales serv-

ices to individuals on a one-on-one basis. Someone, typically an agent, has to make the sale to each individual (and be paid for doing so); each individual is separately billed; and if the person needs service, the insurer rather than the employer, has to attend to the person's needs.

For all of these reasons, even when the individual market performs as well as it can, it is unlikely to account for a major portion of total health coverage.

The Small-Employer Market

The small-employer market in Vermont provides coverage for employers having from 1 to 50 employees. (A self-employed person is a "group of one.") The small-employer market is composed of two sub-markets—the community-rated market and the association market—and each is subject to its own set of insurance regulations. Under both federal and state law, insurers have to offer coverage on a guaranteed-issue basis to *all* small employers;[4] that is, no firm can be denied coverage because of the group's risk. The two sub-markets differ, however, in the way Vermont's community rating rules apply. In the community-rated portion of the small-employer market (hereafter referred to as the small-group market), every firm insured by a particular insurer pays the same rate for comparable coverage; that is, the insurers cannot use an individual group's risk factors or prior claims experience in deciding how much to charge that group. But generally in the association market, community rating applies only *within* the association;[5] all groups in an association pay the same rate for the same coverage, but different associations can be charged different rates. So an association composed of employers with generally low-risk employees—consider a hypothetical association of employers whose employees are fitness trainers—would pay a lower premium than an association in which the covered employees are less healthy, older, or otherwise at higher risk of incurring high medical costs.

Small employers have the choice of whether to join an association, assuming they qualify for membership, or to buy in the community-rated small-group market. Naturally, the choice will generally depend upon which form of coverage is a "better deal." Small employers that meet the eligibility requirements for joining an association that offers lower rates because the association enrolls lower-risk people will have an incentive to leave the small-group market to buy coverage from that association. Employers may qualify for membership in several associations and thus have several coverage choices. Some associations have such open-ended standards for eligibility that almost any business can qualify to join. The result will generally be that the rate advantage that such an association might have initially—and which caused employers to switch to them from the small-group market—will tend disappear over time because employers that belong to most costly associations (because of those associations' higher-risk populations) will switch to the lower-cost association. The influx of those higher-risk people will raise the claims expense of the association and force them to raise premiums. So, over time, rate differences among associations that are open to almost all small employers will tend to disappear. But associations with more limiting eligibility requirements may continue to enjoy lower premiums if the association is composed of people of below-average risk.

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[4] Under federal law, a small group does not include "groups of one." The small-group market is defined as employers with 2 to 50 employees.

[5] Technically, only associations that have been deemed "exempt" associations are allowed to be experience rated rather than community rated. But most people insured through associations are in exempt associations.

Since associations provide other services besides offering health insurance, including offering other kinds of insurance, some employers' choice among coverage options is undoubtedly influenced by the availability of those other services.

THE OBJECTIVES OF MERGING MARKETS

Any major alteration of insurance markets, such as merging the individual and small-employer markets, creates some disruption and uncertainty. Such a policy change is worth undertaking only if the change can reasonably be expected to achieve desirable objectives. It is thus worth examining what objectives might possibly be realized. Five come to mind:

- Make coverage more affordable for people who now pay above-average premiums.
- Increase the range of coverage options, especially for people in the individual market.
- Increase market stability by lowering year-to-year variation in premiums.
- Increase market efficiency and thereby lower insurance costs.
- Ensure that a viable market remains to serve people buying as individuals and to serve small firms that cannot find an appropriate association plan.
- Increase the number of Vermonters who have health insurance.

We consider these in turn.

Make coverage more affordable for people who now pay above-average premiums

In a merged market with community rating, people who now pay different rates for similar coverage would pay the same rate.[6] This means, of course, that people who now pay premiums higher than the average rate (for the three markets considered as a whole) would benefit, while those who now pay a below-average rate would pay more than they do now. Presumably, this would be the intent of making such a policy change. The state of Vermont has made a strong commitment to the principle of community rating, presumably reflecting the view that the amount that a person pays for health insurance should not be dependent on the individual's health status, employment status, or other personal characteristics. Yet the way the markets have evolved over the last few years has resulted in a dilution of this principle.

Small employers with relatively low-risk workers joined associations so that they could be separately risk rated and enjoy lower premiums (although this may not have been the only motivation). As these employers left, those remaining employers in the small-group market experienced rate increases because the average risk level had risen. But this motivated additional, relatively low-risk employers to leave. And the process continued. The fact that there are relatively few employers left in the non-association small-employer market is evidence of this spiral. It is likely that the few who are left remain there because the associations they are eligible to join do not offer a lower price or are unattractive for some other reasons. The fact that the only policies available to the small number of individuals still buying in the individual market are expensive high-

[6] The community rating principle also applies when policies have different benefit packages. In essence, insurers are required to start with the community rate and then adjust the rate to reflect the difference in the actuarial value of the different benefit packages.

deductible policies is evidence that the people left in this market are higher risk and are thus paying substantially more than they would if community rating were applied across the board. Presumably, the insurers would offer more comprehensive plans in this market if they could find customers to buy them, just as they do in other markets. But if the people in the individual market are high risk, the price of comprehensive plans would have to be so high as to make them unaffordable.

A merger of all of these markets would represent a recommitment to the principle of community rating, ensuring that the amount people pay for coverage does not depend on their particular circumstances, most of which are beyond their control.

In assessing the desirability of merging markets to pursue this objective, it is important to recognize an inherent trade-off. *It is worth making the policy change only if the merger would produce significantly lower premiums for a number of people. That will occur, however, only if the premiums differ significantly from market to market. But if rates do differ significantly, the policy will produce some "losers," people whose premiums will increase at least somewhat.* The policy change is a "zero-sum game."

Increase the range of coverage options, especially for people in the individual market

A possible benefit of merging the markets would be that the policies available to people now purchasing coverage in the individual market would be more varied and in particular more like the coverage that is typically purchased by people now buying in the small-employer market. Virtually the only policies now available to individuals are high-deductible plans. That would change if the markets were merged so that individuals could buy the same policies as small employers. But the broadening of coverage options for individuals might not happen automatically unless insurers were required by law to make more comprehensive plans available to people buying as individuals. Otherwise, insurers might find it to their advantage to continue to offer only high-deductible plans to people buying on their own. (Insurers would, of course, be required to make that coverage available for the same premium as offered to small employers choosing those plans.) If the insurers were convinced that the people who were previously buying as individuals were of higher-than-average risk and thus heavy utilizers of medical services, they might prefer to offer only plans that put the insurer at risk for just those costs beyond a high deductible threshold. Thus the policy change would probably need to contain provisions to ensure that individual purchasers had access to a reasonable range of benefit package options. Probably the best approach would be to require insurers to make any benefit package that is available to small employers available to individuals also.

Increase market stability by lowering year-to-year variation in premiums

Larger risk pools are subject to less year-to-year variation in rates, assuming rates reflect claims experience. If an insurer's portion of a market is very small, a few catastrophic cases within that pool can precipitate a large rate increase in the subsequent year to offset the loss. For example, BCBSVT in 2008 has only 101 people enrolled in its small-group risk pool (and the number is declining each year, down from 165 in 2007), which makes the pool subject to substantial rate variations from year to year. When risk pools are large, the law of large numbers dictates that the proportion of high-cost and low-cost cases will stay roughly the same from year to year, so there is less need to adjust premiums to compensate for large fluctuations in costs because such fluctuations are rare. If all the markets are merged into one risk pool for each insurer, that pool would obviously be much larger than any one of the pools the insurer has now.

Increase market efficiency and thereby lower insurance costs

It is likely that a merger of the markets would produce some modest administrative savings, although it would still be more expensive to market and service people buying as individuals, so no substantial savings would be realized from that source. But the number of separate benefit packages for all the markets combined would probably be reduced somewhat, which would make the system more efficient and produce some savings.

However, the administrative savings is likely to be offset by the fact that many people previously insured in the individual market, some significant proportion of whom are relatively high risk, would buy comprehensive coverage, which was not available to them before and which would have been unaffordable if it had been available. The result would be an increase in the total claims costs for the market as a whole.

On balance, it appears that a merged market would be somewhat more efficient because of reduced administrative costs, but total costs might not fall or could even rise because some people would buy more comprehensive coverage than they have now.

Ensure that a viable market remains to serve people buying as individuals and to serve small firms that cannot presently find an appropriate association plan

As the previously displayed data showed, the number of people being served in the individual and small-group (non association) market has declined significantly over the last six or seven years. For individuals, in particular, this is a problem because they have nowhere else to go for coverage. The decline has almost certainly been a result of adverse selection (at least for Blue Cross and Blue Shield), which has caused rates to rise even more rapidly than for the market as a whole, which in turn causes more relatively lower-risk people to drop out. If these trends were to continue, individuals would be unable to find an affordable source of coverage. Merging the markets would solve this problem.

The problem may be less severe for those groups that remain in the non-association small-group market. Apparently, some association plans are open to virtually any small group, so virtually all groups have coverage options. But the associations for which they are eligible may not offer the kind of coverage the group needs, the plan may be too expensive, or it may have some other features that make it inappropriate. Merging the markets would ensure that all small groups have the same coverage options, and at a community rate.

Increase the number of Vermonters who have health insurance

Some people who are favorably inclined to merging Vermont markets may hope that the result would be a reduction in the number of uninsured people. However, it is probably not realistic to think that this outcome would be achieved to any significant extent. Significantly more people are likely to choose to become insured only if premiums fall substantially. Prices could decline substantially for some people whose only option currently is the individual market, which would cause some of them to buy coverage for the first time. But as we explain below, merger of the markets is less likely to produce an appreciable price decline for those now buying in the small-group and association markets. Many of the people who are now uninsured would find coverage affordable only if they became eligible for substantial subsidies.

LIKELY EFFECTS OF MERGING THE MARKETS

A merger of the markets would produce winners and losers. Some would pay more; some would pay less. To trace the effects of merger, we start with the assumption that the people insured in the merged market would be the same as those now insured in the three markets. We will change this assumption later.

The people insured in the individual market would almost certainly pay less than they do now. Currently, individual rates are higher for two reasons (at least for BCBSVT). First, the insured people are likely to be of above-average risk because when guaranteed issue and community rating are in effect, the market tends to attract higher-risk people and few low-risk people. Because the market rules impose no financial penalty for waiting, lower-risk individuals can postpone buying coverage until they anticipate needing expensive medical care.[7] Those who follow this course of action do not pay premiums and contribute to the risk pool when they are healthy and use little care, but they incur high costs when they do buy coverage. They take out more in expenses than they put in as premiums over time.

Second, insurers' administrative costs are higher for serving individuals because of diseconomies of small scale, as noted previously.

Neither of these conditions is likely to change under a merged market, so the insurers' costs of providing coverage for those buying as individuals will remain higher than for small employers. If the costs of insuring these people are averaged in with all people buying small-employer coverage, as would be the case in a merged market, their premiums would fall. Of course, this means that premiums for at least some people in the small-employer market must rise. And as noted previously, claims costs and premiums would also likely rise because the people in the individual market would be more likely to buy more comprehensive coverage plans than those available to them now.

In the small-employer market, it is people insured through associations that would likely pay more if all the markets were merged, although the increase may not be large, for reasons discussed later. The fact that the association market has grown dramatically while the small-group market has declined rapidly indicates that employers are getting a "better deal" by buying association coverage than they could by buying "regular" small-group coverage. The explanation can be traced to the fact that the premiums for an association are based on the risk profile of just the employer groups in the association. That is, insurers are not required to community rate *across* associations, while the small-group market must community rate. Thus relatively low-risk employers had a strong incentive to join together in an association to purchase coverage because they would be charged a lower rate, reflecting their lower risk profile.

As this began to happen, the rates for the small-group market inevitably had to rise, because the lowest-risk groups were leaving to buy association coverage. But the consequence was that the moderate-risk (but still below-average risk) employers left in the small-group market now had reason to try to find an association to insure them. The process continued until there are now few employers left in the small-group (non-association) market. Employers in association plans have an incentive to seek out coverage from the lowest-cost association plan, which over time should

[7] Insurers try to protect themselves against "adverse selection" by imposing pre-existing condition limitations, but this defense is only partially effective.

bring rates closer to the average for all associations. But since not all employers are eligible for membership in all associations and since inertia prevents some employers from aggressively shopping around, rate differentials remain. In a merged market, such differentials would disappear, which means that the employers in associations with members of below-average risk would pay more than they do now.

To summarize, the winners would be people now insured in the individual market and probably the non-association small-employer market. The losers would be the employers in association plans whose premiums are below the average. However, as explained below, the magnitude of the change in relative prices is likely to be less, perhaps much less, in Vermont than it would be in most others states.

It is worth noting that the merger could have different effects on different insurers, depending on their current mix of business. (For example, BCBSVT has almost 70 percent of the association market but almost no enrollment in the non-association small-group market.) The merger would eliminate the price differential between the various segments of the market and might create more favorable competitive conditions for some insurers relative to others. The change would almost certainly cause all the major insurers to rethink how they market and price their products to gain market share while managing risk. It is probably impossible to predict the outcome of that process.

HOW DISRUPTIVE WOULD A MERGER BE?

If a merger of markets causes major changes in relative or absolute premiums for various market segments, it would be quite disruptive in the short run. However, a merger of the small-employer and individual markets in Vermont would likely be less disruptive than in other states for several reasons.

To analyze the probable extent of disruption, we need to alter the previous simplifying assumption that the same people would remain insured so that the risk profile of the combined markets would not change. That is not a realistic assumption. When rates change, some new people will enter the market and some who had been insured probably will leave, and these shifts will affect relative prices.

In most states, merging the small-group and individual markets would cause severe adverse selection against the individual market because of differences in the rating rules in the two markets.

Market Merger in Massachusetts

It is useful to review the experience of the state of Massachusetts since the state merged the individual and small-employer markets. Prior to the reform, actuaries estimated that the merger would cause premiums for the individual market to fall by about 15 percent while rates in the small-group market would rise by perhaps 1 percent to 2 percent. Although no rigorous study has been done to trace premium changes in the year and a half since the law took effect, according to Massachusetts officials, the indirect evidence suggests that the reduction in price for individuals was much larger than the estimates while there was probably no increase in the small-group rates attributable to the merger.

The Massachusetts experience may be instructive since, like Vermont but unlike most other states, in Massachusetts the market rules for the individual and small-group markets were very similar prior to the merger. Of course, one very important additional element of the Massachusetts reform was the requirement that everyone have coverage, which would have the effect of bringing into the insurance pool many low-risk people who previously had gone without coverage. Such an influx would produce lower rates. But the officials at the Massachusetts Connector believe that the effects of this improvement in the risk profile have not yet had an effect on premiums for people seeking coverage as individuals. Once insurers adjust their premiums to reflect the improved risk profile, premiums for individuals should be lower than they are now. The number of lower-risk people entering the market may increase in future years because the penalty for not complying with the mandate was small in the first year but will become much higher in future years. So some "holdouts" will likely newly buy coverage then.

Typically, coverage is not available on a guaranteed-issue basis to individuals; high-risk applicants can be denied coverage entirely (but federal law requires that coverage be available on a guaranteed-issue basis for small groups). Further, the individual market rules generally allow considerably more rate variation than in the small-group market; high-risk individuals pay much more than low-risk individuals. In these circumstances, applying the small-group market rules to the individual market, as happens when markets are merged, would make coverage available at a considerably lower cost to people whose only previous option was the individual market. That would almost certainly produce a large influx of high-risk individuals who previously could not get coverage at all or only at rates that were unaffordable. The result would be severe adverse selection against the merged market, and rates would likely rise appreciably. But in Vermont this would not happen because coverage is *already* available to individuals on a community-rated, guaranteed-issue basis. *The individual market has already absorbed the adverse selection resulting from the fact that people cannot be denied coverage and face no financial penalty when they wait to buy coverage until they are at high risk of needing medical care.*

In Vermont, in a merged market, the price of coverage would fall for people whose only previous option was the individual market. How would this affect who buys insurance and premiums? In particular, would it change the risk composition of the combined market? A lower premium would certainly make coverage more attractive to some individuals who were previously "on the fence" with regard to buying coverage: more people would decide that coverage was a "good buy." But there is no reason to conclude that the individuals who would be newly attracted to the market would be disproportionately people with above-average risk. Because of Vermont's requirement of guaranteed issue in the individual market, many high-risk individuals are already in that market. Lower rates should make coverage attractive to the *lower*-risk people who stayed uninsured because the previous high rates did not make coverage seem to be a good value. The influx of lower-risk individuals would help to bring down the average cost of insurance, although some low-risk individuals would still decide against buying coverage. It is reasonable to expect that the individuals who newly buy coverage would *at worst* represent a cross-section of risk. Even so, because some low-risk people will still choose to remain uninsured, the claims experience of the individuals is likely to remain worse than for people who are insured as part of a group, which means that a merger would cause some upward pressure on prices for people now in the small-employer market.

As noted earlier, administrative costs are significantly higher in the individual market because of diseconomies of scale. The higher costs of serving individuals do not disappear when markets are merged, and those costs would be reflected in higher rates for the people now buying in the small-employer market.

Since there are always employers "on the fence" about offering coverage, a price increase would cause some of them to not enter the market or to drop coverage. Such a response is most likely from employers with relatively low-risk workers, for whom the value of coverage is somewhat less than for workers more likely to need expensive medical care. However, the research shows that employers are not very sensitive to small price changes; the number either dropping coverage or newly offering it is not likely to be high unless the price change is large.[8]

[8] James D. Reschovsky and Jack Hadley, "Employer Health Insurance Premium Subsidies Unlikely to Enhance Coverage Significantly," Issue Brief: Findings from HSC, No. 46, Center for Studying Health Systems Change, December 2001.

The *magnitude* of the relative price changes is obviously very important. Merging the individual market with the small-employer market is not likely to precipitate a large price change simply because the individual market is so small. People insured in the individual market represent less than 7 percent of the total covered lives in the three markets combined. The market is small because nearly everybody who has had the option to switch to group coverage has already done so because of the financial advantage and the availability of more comprehensive coverage. The following hypothetical example shows that the small relative size of the individual markets mitigates any price increase resulting from merger.

Hypothetical Examples

Assume the insurer's cost for insuring individuals is 40 percent higher than for groups, so their premiums are 1.4 times as much. To make the math easy, assume an employee in an average group pays $100 now and the same coverage costs $140 for a person buying coverage as an individual. If there were no change in the composition of the risk pool as a result of the merger (and the individual market accounts for 7 percent of the total), the average premium would rise to $102.80, adding $2.80 to the premium for people in the small-group market and reducing premiums for individuals by $37.20. As was suggested earlier, however, merging the markets could induce some lower-risk individuals to newly enter the market, which would help to moderate any price increase.

The table below illustrates that the extent of disruption—that is, the magnitude of premium changes—depends on the extent of rate variation existing in the market before the merger, as well as the proportion of higher-risk and lower-risk enrollees. The table is an example of the difference in effects in the association market under three scenarios (which are purely hypothetical, that is, not based on realistic data): narrow rate variation, modest rate variation, and substantial variation. In each instance, the number of enrollees is the same (100) and the total premium is almost the same (about $10,200), but the change in premium resulting from market merger is much different in the three scenarios. Not surprisingly, the rate change is much larger when there is wide dispersion of rates, which can be seen by looking at the last two lines in each scenario. Some people enjoy large savings, while others pay much more for coverage. (It should be noted that Scenario 3 is not a realistic scenario. If premiums differences were as large as in the illustration before the merger, the Infiniti Association would have a very difficult time maintaining any enrollment.)

FIGURE 5

A - Narrow Rate Vartiaion Scenario — 1.2:1 Variation

Before Merger

	Acme Association	*Beneficial Association*	*Consolidated Association*	***All Associations Combined***
Number of enrollees	25	50	25	**100**
Premium per enrollee	$ 95	$ 100	$ 115	
Total premium	$ 2,375	$ 5,000	$ 2,875	**$ 10,250**
Average premium/community rate premium				**$ 102.50**
After Merger				
Post-merger premium	$ 102.50	$ 102.50	$ 102.50	
Change in premium	$ 6.25	$ 1.25	$ (13.75)	**$ -**
Percent change	7%	1%	-12%	**0%**

B - Moderate Rate Variation Scenario — 2:1 Variation

Before Merger

	Dover Association	*Excell Association*	*Fulton Association*	***All Associations Combined***
Number of enrollees	25	60	15	**100**
Premium per enrollee	$ 75	$ 100	$ 150	
Total premium	$ 1,875	$ 6,000	$ 2,250	**$ 10,125**
Average premium/community rate premium				**$ 101.25**
After Merger				
Post-merger premium	$ 101.25	$ 101.25	$ 101.25	
Change in premium	$ 26.25	$ 1.25	$ (48.75)	**$ -**
Percent change	35%	1%	-33%	**0%**

C - Wide Rate Variation Scenario — 4:1 Variation

Before Merger

	Gallant Association	*Hightop Association*	*Infiniti Association*	***All Associations Combined***
Number of enrollees	7	86	7	**100**
Premium per enrollee	$ 45	$ 100	$ 180	
Total premium	$ 315	$ 8,600	$ 1,260	**$ 10,175**
Average premium/community rate premium				**$ 101.75**
After Merger				
Post-merger premium	$ 101.75	$ 101.75	$ 101.75	
Change in premium	$ 56.25	$ 1.25	$ (78.75)	**$ -**
Percent change	125%	1%	-44%	**0%**

Vermont Data

Extensive data showing actual premium variations among Vermont's various markets for identical benefit packages is not readily available. Some data on the association market is available, however.

Data From Blue Cross and Blue Shield of Vermont for five associations and eight benefit packages[9] show that the range of premium variation for similar benefit packages is generally not very large from association to association. For five of the eight benefit packages, the premium variation across associations does not exceed 15 percent: the range is from 4 percent to 15 percent. The range of variation for the other three benefit packages is between 32 percent and 56 percent.

Generally speaking, the association with the highest premium rate for a given benefit package tends to have fewer enrollees than the associations with lower rates. Yet for a different benefit package, these same smaller associations frequently do not have the highest rate. For two benefit packages, the association with the highest premium is a large association, although in this instance the rate variation across associations is less than 14 percent.

When rate variations are large—in the range of 50 percent—the associations with the highest premiums are generally small. Hence, under a merged market with a community rate for all associations as well as the rest of the market, the effect on the premium would be relatively small when the small association is merged with the rest of the market.[10]

Data showing the differences in premium variations across all three markets— associations, the non-association small-employer market, and the individual market—is limited. For one product, an HSA product that was sold both to two associations and in the individual market, the individual market price was about 83 percent higher than the association price. For small-groups, the rates were between 55 percent and 70 percent higher than for associations with similar coverage.[11]

These premium variations reflect the different claims experience of the people enrolled in each plan. Such variations would be eliminated under a merged market because community rating would be applied across the board, reflecting the combined claims experience of the association, small-group, and individual markets.

It appears that the rate variations in Vermont are not so large that a merger of the three markets would cause large rate increases for significant numbers of people. The variations in the association market are generally not large, and in the cases where they are larger, it is generally the plans with relatively few enrollees that have higher rates. Thus applying community rating across all associations would not cause rates to rise very much for associations currently enjoying lower rates. Rate variations between associations, on one hand, and the small-group and individual markets, on the other, may be somewhat greater. But associations account for 77 percent of enrollment in the three markets, with small-group enrollment making up 16 percent and individual enrollees accounting for just 7 percent. The large relative enrollment in associations means that applying community rating across all three markets would likely produce noticeably lower

[9] Not all associations offer each of the eight benefit packages.
[10] Based on the author's analysis of data supplied by Blue Cross and Blue Shield of Vermont.
[11] Based on analysis provided in personal communication from Steven Kappel.

rates for people now enrolled in the individual and small-group markets without causing large increases in rates for people now in association plans.

HYPOTHETICAL EXAMPLES OF THE EFFECTS OF MERGERS ON PREMIUMS IN VARIOUS MARKETS[12]

Across all Three Markets

To give some sense of how a merger of markets might affect premiums in the three relevant markets, we prepared an example (Figure 6) that is more realistic than the purely hypothetical example provided earlier. However, this is still a hypothetical example in the sense that because of data inadequacies, we were forced to make assumptions that we think are somewhat realistic but not based on data. These assumptions have a major effect on the results of the analysis. Specifically, we made assumptions about the risk differences among the markets (which we refer to as "selection effect," shown in Column C) and the differences in the comprehensiveness of coverage (which we refer to as "benefit effect,"[13] shown in Column F). Our starting point for the calculations was the actual 2007 data for each market, specifically the total enrollment in each and the total premiums for each, which are reported annually to the Department of Banking, Insurance, Securities, and Health Care Administration. This data allowed us to calculate the monthly average premium for each market: $247 for the individual market, $370 for the small-group market, and $317 for the association market (Column H). Based on these data points, we made what we think are reasonable assumptions about the selection effect and the benefit effect reflected in these monthly premium differences. As shown in Column C, we assumed that the relative risk of the individual market population is 29 percent higher than for the association market, and the small-group market risk level is 17 percent higher than for the association market. As shown in Column F, we assumed that relative to the association market, benefit levels in the individual market were only 61 percent as high, while the benefit levels of the small-group market are essentially the same as in the association market.

Using these data points, it is possible to calculate how merging the markets and thus imposing community rating across all three markets would affect premiums (Column H) and total costs (premiums plus out-of-pocket expenses-Column K). (The shaded columns in the table are the most relevant for the following discussion.) We started by assuming insurers were required to community rate but the people enrolled in each market choose to retain the benefit levels they originally had. Although this assumption is unrealistic, it allows us to separate out the effects of community rating from benefit changes. Under these circumstances, despite community rating, the premiums would not be identical in the three markets: markets with lower benefit levels would have lower premiums even though the selection effects had been eliminated. Our calculations show that under this scenario—referred to as "Shared Experience (Community Rating), Current Benefits"—in the table, the average monthly premium in the individual market would

[12] In working out these examples, the author was ably assisted by Steven Kappel of Policy Integrity, LLC. He is not responsible, however, for any errors contained in the analysis.

[13] In reality, the benefit effect includes not only differences in the richness of coverage but also differences in administrative costs from market to market.

FIGURE 6 – HYPOTHETICAL EXAMPLE OF EFFECTS OF MARKET MERGER

Three-Market Example

	A	B	C	D	E	F	G	H	I	J	K	L
CURRENT	*Enrollment*	*Total Monthly Medical Expense Per Enrollee*	Selection Effect Ratio: Medical Expense as % of Association Medical Expense	*Total Monthly Medical Costs*	*% Paid by Insurance*	Benefits Effect Ratio: % Paid by Insurance Divided by Association % Paid by Insurance	*$ Paid by Insurance*	*Monthly Insurance Premium*	*Monthly Out-of Pocket Expense*	*Total Employer/ Employee Cost per Month (Insurance Premium and Out-of-Pocket)*	*Total of Insurance Premium and Out of Pocket*	*Ratio of New Total Cost to Old Total Cost*
Individual	8,964	$450	129%	$4,033,800	55%	61%	$2,216,205	$247	$203	$450	$4,033,800	100%
Small Group	19,681	$410	117%	$8,069,210	90%	100%	$7,275,164	$370	$40	$410	$8,069,210	100%
Association	95,666	$350	100%	$33,483,100	90%	100%	$30,288,675	$317	$33	$350	$33,483,100	100%
Total	124,311	$367		$45,586,110	87%		$39,780,045	$320	$47	$367	$45,586,110	100%
SHARED EXPERIENCE (COMMUNITY RATING), CURRENT BENEFITS												
Individual	8,964	$450	129%	$4,033,800	55%	61%	$1,793,937	$200	$203	$403	$3,611,532	90%
Small Group	19,681	$410	117%	$8,069,210	90%	100%	$6,463,514	$328	$40	$369	$7,257,559	90%
Association	95,666	$350	100%	$33,483,100	90%	100%	$31,522,594	$330	$33	$363	$34,717,019	104%
Total	124,311	$367		$45,586,110	87%		$39,780,045	$320	$47	$367	$45,586,110	100%
SHARED EXPERIENCE (COMMUNITY RATING), BEST BENEFITS												
Individual	8,964	$450	129%	$4,033,800	90%	100%	$3,266,977	$332	$38	$370	$3,318,134	82%
Small Group	19,681	$410	117%	$8,069,210	90%	100%	$6,565,158	$332	$35	$367	$7,221,071	89%
Association	95,666	$350	100%	$33,483,100	90%	100%	$31,404,873	$332	$35	$366	$35,046,905	105%
Total	124,311	$367		$45,586,110	90%	100%	$41,237,008	$332	$35	$367	$45,586,110	100%

Association Example

CURRENT (SAME BENEFITS ASSUMED)												
Association 1	10,200	$420	120%	$4,284,000	90%	100%	$3,855,600	$378	$42	$420	$4,284,000	100%
Association 2	75,000	$349	100%	$26,175,000	90%	100%	$23,557,500	$314	$35	$349	$26,175,000	100%
Association 3	10,466	$300	86%	$3,139,800	90%	100%	$2,825,820	$270	$30	$300	$3,139,800	100%
Total	95,666	$351		$33,598,800	90%	100%	$30,238,920	$316	$35	$351	$33,598,800	100%
SHARED EXPERIENCE (COMMUNITY RATING), BEST BENEFITS												
Association 1	10,200	$420	120%	$4,284,000	90%	100%	$3,855,600	$332	$42	$374	$3,811,990	89%
Association 2	75,000	$349	100%	$26,175,000	90%	100%	$23,557,500	$332	$35	$367	$27,496,840	105%
Association 3	10,466	$300	86%	$3,139,800	90%	100%	$2,825,820	$332	$30	$362	$3,785,809	121%
Total	95,666	$351		$33,598,800	90%	100%	$30,238,920	$332	$19	$351	$35,094,639	100%

Note: This analysis assumes that reducing the out-of-pocket liability of insured people causes no increase in their utilization of services, which is a useful assumption for this analysis but is probably not realistic.

fall from $247 to $200, a decrease of $47[14] (Column H), and the total medical costs (premium of $200 plus out-of-pocket costs of $203 = $403) would be 10 percent lower than when there was no community rating (when it was $247 + $203 = $450). (See Column K.) The premium for the small-group market would decline by $42, from $370 to $328, and the sum of premium plus out-of-pocket cost ($328 + $40 = $369[15]) would be 10 percent lower than originally ($317 + $33 = $350). The association market would experience a premium increase of $13, from $317 to $330, and total costs of the premiums plus out-of-pocket expenses would increase by 4 percent (Column L).

Going one step further, if we assume community rating across all three markets and benefits in all markets equal to those in the association market—the scenario referred to as "Shared Experience (Community Rating), Best Benefits" in the table—the changes are larger but still modest. The premium would be identical in all markets. Compared to the original situation, with no community rating and different benefits, the premium in the original market would go up from $247 to $332, an $85 increase (Column H), reflecting the more comprehensive coverage, which translates to lower out-of-pocket costs. The net effect is that total costs for premium plus out-of-pocket expenses would decline by 18 percent (Column L). The small-group market would realize a premium decrease of $38, going from $370 to $332, and a total cost reduction of 11 percent. The association market would experience a $15 premium increase compared to the original (current) scenario, from $317 to $332, and the total costs for premium plus out-of-pocket would rise by 5 percent.

It is important to emphasize that the assumptions we made about the selection and benefit effects determine the extent of the premium and out-of-pocket cost changes and that the assumptions are not based on "hard" data. If we had assumed a lesser selection effect (that is, that the risk differences from market to market are less than we assumed), the changes under community rating would be less. Likewise, had we assumed less in the way of benefit differences, the changes would be smaller. (See the Appendix for another example, which assumes a larger selection effect and larger benefit effect.)

But the significant conclusion is that even when we assume significant selection and benefit effects, the premium and out-of-pocket cost increases are confined to the association market and are not large—in the range of 5 percent.

Within the Association Market

We prepared a similar—but decidedly more hypothetical—example to show possible changes in premium and out-of-pocket costs from association to association under a merger of markets. We started by assuming essentially the total association membership and average premium that now prevail in the association market. We assumed that most of the associations have about the same risk profile and benefit levels but that a relative small proportion of the market is composed of associations that are significantly different with respect to their risk profile, some being made up of members of below-average risk (assumed to represent about 11 percent of total association enrollment) and others with members of above-average risk (also assumed to be about represent about 11 percent of total association enrollment). (See Column A). We assumed the higher-risk association group to have a risk level about 20 percent higher than average, the low-risk associa-

[14] Minor discrepancies between the text and the table are due to rounding.
[15] Totals do not add because of rounding.

tion group to have a risk level equal to about 86 percent of the average, and for the large association to have a risk level equal to the average for all the associations (100 percent). We assumed the same benefit levels for all associations.

Under these assumptions, merging markets and imposing community rating across all associations and all markets would produce a significant change in premiums for the associations that are composed of enrollees with risk levels that diverge significantly from the average (Column L). Under community rating, the high-risk association would benefit, as expected: their total cost for premium plus out-of-pocket expenses would be 11 percent below the previous level. The association composed of low-risk enrollees would experience a 21 total cost increase. The large association composed of people of average risk would pay 5 percent more than before the merger.

In interpreting this data, it is important to emphasize that the assumptions drive the conclusions regarding rate changes. If the risk differences across the associations are substantially less than in this hypothetical example, the rate changes for all associations would be correspondingly smaller. If the risk differences are larger, the rate changes would be larger. Unfortunately, we do not have sufficient data to determine which scenario is closer to the real situation.

MERGING THE MARKETS

Principles for Any Insurance Reform

Any approach to reform of insurance markets needs to be consistent with moving toward certain objectives on which there is wide agreement. It is useful to keep these objectives in mind in assessing particular approaches to changing insurance market structures:

- Promote a fair sharing of risk among high-, moderate-, and low-risk insured people.
- Encourage as many people as possible to acquire coverage.
- Encourage both high-risk and low-risk people to buy coverage.
- Promote horizontal equity so that people in essentially equal circumstances with respect to ability to pay are required to pay the same amount for essentially identical coverage.
- Promote vertical equity so that the amount people pay for coverage is affordable and related to their income level.
- Avoid sudden, very large rate increases for any segment of the insured population.
- Not promote inefficiency or add to health care costs.

Unfortunately, as with most public policy decisions, there are probably no policy options that are fully consistent with all of these objectives. Trade-offs among the objectives are virtually inevitable.

Issues in Implementation

There are a number of separate risk pools in the Vermont small-employer and individual markets:

- *Association plans.* Each insurer offering association coverage charges a different (community) rate to each association (for actuarially equivalent benefit packages) based on the actual claims experience of the association.
- *Small group.* Small-group insurers are required to community rate; so every group pays the same premium for comparable coverage regardless of the group membership or their claims experience.
- *BCBSVT individual.* BCBSVT is required to community rate their individual market business, so everyone pays the same premium for comparable coverage regardless of their risk. BCBSVT reports that the risk profile of this population is substantially worse than for the rest of their insured populations.[16]
- *For-profit individual.* For-profit insurers in the individual market (essentially MVP) are allowed to vary rates by plus or minus 20 percent based on the age of the individual seeking coverage. MVP reports that the risk profile of this population does not differ significantly from that of the other people they insure.[17]
- *BCBSVT Safety Net.* In 1992 when the state made major reforms in the insurance laws, a number of insurers chose to leave the state. BCBSVT was required to make comparable coverage available to the people that the withdrawing carriers had insured. In addition, BCBSVT could not raise premiums by more than 15 percent per year. This provision was to protect these people—thought to be of below-average risk—from facing major premium increases. According to BCBSVT, this constraint on rate increases prevents BCBSVT from charging premiums that are sufficient to cover the claims costs of the Safety Net population.
- *Catamount Health.* This risk pool is made up of people who are eligible because they have been uninsured for at least 12 months or have incurred some life-changing event, such as job loss, divorce, or death of a spouse. Coverage costs are subsidized for people whose income falls below 300 percent of the federal poverty level, which was $2,600 per month for an individual and $3,500 per month for a couple in 2008.

If policymakers in Vermont decided to merge the small-employer and individual markets, they would have to decide which of these markets to merge. One possibility would be to merge just the individual market and the small-group (non-association) market. This does not seem like a sensible option. Each of these markets has experienced large enrollment reductions in recent years (see Figure 1), and together they account for only about 28,600 enrollees, which is only 23 percent of the total of the individual, small-group, and association markets and about 8 percent of the total privately covered population. These two markets appear to be in decline, and merging them alone is unlikely to arrest that decline and unlikely to move the state further along the path toward achieving the other objectives outlined above.

The question remains about whether to merge all six of these risk pools into one. From both the standpoint of equity and efficiency, a case can be made for merging at least the first five risk pools. The principle of horizontal equity requires that everyone in essentially equal circumstances be treated equally. When there are separate risk pools, even when community rating applies *within* the pool, people in one pool will often pay more for coverage than people in equal circumstances in another pool. For example, a 55-year-old man with one chronic condition but otherwise

[16] Personal communication.
[17] Personal communication.

in good health who buys individual insurance would almost certainly pay substantially more than a man of the same age and medical condition who is covered by an association plan or who has coverage through the Safety Net program. The same kind of premium difference undoubtedly occurs between similarly situated individuals insured by different association plans. Even if the state had not made a commitment to community rating, such unequal treatment of people in equal circumstances seems inequitable. Merging the various risk pools would eliminate this inequity.

Catamount Health might be considered a special case because of its unique purpose. The intent of this program is to offer subsidized coverage to people who would otherwise find coverage unaffordable. The subsidy has two elements: (1) to people with incomes of less than 300 percent of the federal poverty level the state offers what amounts to a discount off the actual cost of providing coverage, and (2) providers have agreed to be paid rates that are below what they typically receive for the covered services.

Catamount as a Separate Risk Pool

It could be argued that this coverage plan should be thought of as something apart from the rest of the relevant markets—as a subsidized program designed especially for a certain needy population, in the same sense that Medicaid is such a program. They both cover a defined population with a particular benefit package, and provider payments rates differ from those of the commercial insurance market. From this perspective, it could be argued that it would make sense to not merge Catamount Health with the rest of the individual and small-employer markets.

If Catamount Health were to remain a separate risk pool, it would remain essentially as it is now: premiums would be based on the experience of Catamount members alone; eligibility for enrollment would be limited to those previously without health insurance or those having undergone some major change in life status; premium subsidies would be available to those meeting the income eligibility test; and everyone in the program would benefit from the indirect subsidy attributable to the discounted provider rates.

Catamount Merged with the Other Risk Pools

On the other hand, merging Catamount Health with the rest of the relevant market has some advantages. Catamount Health now enrolls about 6,500 persons,[18] which makes it about 70 percent as large as the "regular" individual market. Merging it in with the rest of the individual and the small-employer market (including association plans) would help to add rate stability to all of the markets, for the reasons explained above. Such a merger would also be "more tidy" by avoiding having just this portion of the individual market outside the now large community-rated risk pool.

But a "straight" merger of Catamount Health with the other markets would be inconsistent with the objectives of Catamount Health. If Catamount Health were merged with the other risk pools and enrollees were charged the community-rated premium without a subsidy, the premium for the Catamount benefit package would be too high to be affordable. Later we make the argument that every benefit plan available in a merged market should be available to any individual or group. But this does not seem practical in the case of the Catamount benefit plan because the

[18] Enrollment in Catamount Health as of October 2008 was 6,537 (5,684 receive some level of premium assistance, and 853 do not. Personal communication, Sarah Rugnetta, Department of Banking, Insurance, Securities and Health Care Administration.

providers in effect subsidize this plan by providing services at discounted rates. It unlikely that they would be willing to offer discounted coverage to higher-income people selecting this coverage, and there would be no justification for asking them to do so.

If Catamount Health is merged with the rest of the individual and small-employer markets, it should probably have the following features:

- Eligibility for the Catamount benefit program would be limited to those who are eligible for the program in its present form. Unlike other benefit packages, it would not be open to all.
- Providers would continue to offer discounted rates to Catamount enrollees.
- Catamount Health would be part of the merged risk pool, and premiums would be based on the community rate for the merged pool *but with the following adjustments:*
  - An adjustment for differences in the design of benefit package (as with all different benefit designs).
  - A downward adjustment to reflect the fact that providers offer their services at a discounted rate for those enrolled in Catamount Health.

It is worth noting that this approach would eliminate any advantage or disadvantage the Catamount enrollees may currently experience because of a favorable or unfavorable risk profile compared to the rest of the population in the individual and small-employer markets. If the enrollees represent a population of below-average risk, the rates would rise under a merger because community rating would apply across the whole merged population. If the Catamount population now has a less favorable risk profile that the rest of population subject to merger, the merger would cause premiums to decline somewhat for the Catamount population.

Horizontal Inequities

It is important, however, to recognize that Catamount Health does produce some significant horizontal inequities that seem inconsistent with the underlying rationale for community rating and market merger. The program provides subsidies to lower-income people who have previously been uninsured for at least a year, but it does not subsidize coverage for people of equal incomes (and therefore no greater ability to pay) who have already bought coverage. What is perhaps even more inequitable is that once people qualify for the program, they continue to be subsidized for as long as they meet the income requirements. Although such eligibility requirements clearly create horizontal inequities, eliminating those inequities by offering subsidized coverage to people based on just their income with no consideration of their previous insurance status would increase the cost of the program. In the long run, however, it may be worth considering whether it would be practical to open up the program to lower-income people even if they are or have recently been insured.

Possible Approaches to Merger

Although a merger is a fairly straightforward process, it is more likely to go smoothly and have fewer adverse effects on insured people if insurers are required to follow certain procedures. The state may wish to consider regulation in the following areas:

1. *Product offerings:* Require all insurers to offer all products to anyone, group or individual.

Presumably in a merged market, all insurers serving small employers would have to make all their coverage options available to any small employer and any individual. If insurers were instead allowed to offer some benefit plans to some customers and not others (for example, to just some association plans or to association plans but not to individuals) the result would likely be segmentation of risk. Insurers would have an incentive to offer more comprehensive plans to lower-risk customers, who would be less likely to make extensive use of the services, and to restrict higher-risk customers to less comprehensive plans. Such an outcome would be inconsistent with some of the objectives of merging markets. (It is important to recognize that some of the insurers that offer coverage to small employers today do not offer individual coverage. Presumably, they would be required to do so in the merged market, which would require some more-than-trivial administrative changes for these insurers.)

Once the merger is fully implemented, the insurer's premium for a person would be the same regardless of whether he or she was buying as a member of a small group or an association or as an individual; in other words, each insurer would have just one risk pool for the combined markets. Differences in administrative costs among the markets would not be reflected in premium differences.[19] Many employers would probably still buy coverage from an association if the association offers other services or types of insurance that made it attractive, but the health insurance premium could not be based, as now, on the experience of the insured people in just that association.

2. *Phase-in:* Require insurers to document the extent of current rate variation among their small-group, association, and individual market segments and then to eliminate the variation over three years by reducing the variation by approximately one-third per year.

As discussed earlier, a merger would cause rates to go up for some and down for others. Certainly none of those whose premiums fell would complain, but the people experiencing an increased attributable to the merger might be upset. One way to reduce the pain would be to phase in the rate changes over several years, perhaps three years, for example. People getting a premium increase would get a smaller increase for each of the three years rather than a single large increase at the point the merger becomes effective. In practice, this would mean that people who are now paying above-average rates would see those rates gradually decrease (compared to what they would otherwise be), while people whose current premiums are below average would see gradual increases over the three-year period.

It would be important to place some constraints on the way insurers phase in the rate changes over that period. Otherwise, some insurers might try to "game" the premium change in such a way as to attract lower-risk enrollees and thereby gain a competitive advantage. For example, if an insurer wanted to avoid enrolling more (presumably higher-risk) people who previously had been in the individual market, the insurer might wait until the third year to reduce the premium for individuals as compared to the group rate. To reduce the potential for such gaming, the state could require that insurers reduce the differential among all their risk pools by approximately one-third for each of the three years. To ensure that this rule is being followed, the state should require insurers to document the extent of rate variation among all their risk pools and then show how they are reducing that variation in each of three years. The technical details would need to

[19] Insurers would be allowed to adjust premiums for not just benefit differences but also for cost differences among products that were attributable to implementation of cost saving elements, such as negotiated provider discounts or utilization controls.

be worked out, but the basic idea is that the insurers would have to show the premium difference among all of their market segments for an actuarially equivalent benefit package.

Rating methodology

The 1992 reforms in Vermont's small-group and individual market rules represented a major departure from the past, moving the state far toward community rating. But the state's commitment to community rating seemed to be somewhat ambivalent, allowing for a number of exceptions from a strict application of that rating methodology. The consequence was, as previously noted, a proliferation of separate risk pools, with community rating applying to each pool separately. The ambivalence is understandable. Community rating has the virtue that it ensures that people are not financially penalized because of poorer health status or greater likelihood of needing expensive medical services. But it has the disadvantage of discouraging lower-risk people from buying insurance by raising their premiums well above what they would pay if insurers were permitted to risk rate. As a consequence, in the absence of a mandate that requires everyone to have coverage, some low-risk people, especially young healthy people, conclude that buying coverage is not a good value: given the relatively low risk, the price is too high. Any rating methodology represents a trade-off between making coverage affordable for high-risk people and not deterring low-risk people from buying coverage. Community rating decides that balance in favor of making coverage less expensive for people of above-average risk.

A straightforward merger of all of the relevant markets under the current rating rules would establish community rating across the board. The result would be that some people currently in risk pools made up of lower-risk individuals would face premium increases, and some of these might decide to drop coverage. However, because the current rating rules do not permit wide disparities in premiums across the various markets, it is unlikely that any premium increases would be large enough to cause a major exodus of such people from the market. But the people who experience a rate increase would surely make their displeasure known.

One way to mitigate the level of disruption would be for the state to adopt a rating methodology that stops short of pure community rating. In particular, the state could allow some modest rate variation based upon age alone across all markets, as is already permitted for individual coverage sold by for-profit insurers. Age is a reasonably good proxy for medical risk because the need for expensive medical care increases with age. Allowing modest age rating would probably reduce the extent of "sticker shock" that might otherwise be experienced by people in association plans that now enjoy below-average premiums.

Among other states that have considered moving toward community rating, there seems to be a consensus that age rating is a reasonable way to balance the need to protect high-risk people from high rates while still ensuring that low-risk people are not deterred from buying coverage. Massachusetts, for example, allows age rating, and when California was considering major reforms, there was a consensus that age rating should be permitted.

Age rating has the advantage that it is roughly consistent with the principle of ability to pay. In general, younger people are more likely to have lower incomes than older people who are further along in their careers. Younger people in the early stages of their work lives can less easily afford coverage, and so age rating, by lowering their premiums, would increase the number of people in this age group who choose to purchase coverage. The inclusion of more young people in the risk

pool would cause the average rate to fall, making it less likely that older people would drop coverage.

Because the state made a major commitment to community rating in the 1990s, it would be inconsistent with that commitment to allow large rate variations based on age or any other characteristic. To do so would be to price some older people out of the market. Although there is no magic number that represents the "right" degree of age rating, a reasonable starting point for discussion is the plus or minus 20 percent that is now allowed for for-profit insurers in the individual market. Applying that rule means that if the average premium is $100, the youngest person would pay $80, while the oldest person would pay $120—a total variation of 50 percent ($120/$80 = 1.5). Allowing any greater degree of a variation would seem to be too great a departure from community rating.

CONCLUSION

In deciding whether to support a merger of the individual and small-employer markets, policy makers have to identify what they expect to accomplish, judge whether those objectives can be realized, and decide whether the outcome justifies the costs of making such a change.

If the main objective is to increase the number of Vermont residents with health insurance, a merger of markets is unlikely to produce that outcome. Some lower-risk individuals who do not now find coverage to be a good deal might be able to buy coverage less expensively in a merged market and decide to become insured. Some higher-risk people who are not eligible for a plan that is both affordable and meets their needs and are thus uninsured now might have access to less expensive coverage in a merged market. But some other people whose rates could increase might drop coverage. The net result is likely to be little change in the number of uninsured.

What a merger would help to accomplish is to improve equity—by moving the state further toward the goal of ensuring equal treatment of people in equal circumstances, what economists call horizontal equity. When the state made the commitment to community rating and guaranteed issue, it presumably did so to ensure that people who are at higher risk of needing medical services—because of age, gender, past medical history, current health status, place of employment, etc.—would not be penalized when they seek to buy insurance coverage. High-risk, average-risk, and low-risk people pay the same amount for the same coverage under community rating. But when Vermont made this commitment, it left the system with loopholes. Rather than applying community rating across the board, the system created a number of separate risk pools: the individual market, the non-association small-group market, each association as a separate risk pool, the Safety Net pool, etc. The inevitable consequence is that people pay different rates for similar coverage, depending on the risk pool in which they are included. People whose only option is the individual market are particularly likely to pay more for coverage than someone who has access to an association plan. Such disparities are not equitable and not consistent with the principle of community rating. They would be eliminated in a merged market.

Even in a merged market one conspicuous inequity would remain: When there is no mandate to purchase coverage, some low-risk people will choose to postpone buying coverage until they anticipate needing expensive medical care. Thus they do not pay their fair share of costs, taking more out of the system to pay for medical costs as a group than they put in as premiums.

Under a merger, equity would also be enhanced because everyone would have access to the whole range of benefit options that would be available. Under the present system, the people buying coverage in the individual market are handicapped by having access to only high-deductible plans.

A merger would help to bring stability to the market as a whole. The individual and small-group markets have experienced such large enrollment declines since 2000 that, if the trends continue, it is unlikely that these markets can be effectively sustained. When enrollment falls too far, per-member administrative costs rise. Some insurers may eventually decide not to serve these markets because the return is too low to justify the effort. Moreover, when individual insurers have risk pools as small as some do, year-to-year premium fluctuations can be large because the risk pool is not large enough to absorb an unusual one-year concentration of high-cost medical claims. However, if each insurer has just one risk pool representing all people insured in the merged markets, the numbers would generally be large enough to greatly reduce year-to-year variations in aggregate medical claims costs.

Merging markets is not without disadvantages—at least, from a political perspective. As explained above, a merger would improve horizontal equity by lowering premiums for people who now pay more because they are part of a higher-cost risk pool. But the flip side of improving equity is that the people who now pass less for coverage must pay more under the new system (unless the new system attracts significant numbers of lower-risk people who are now uninsured). Obviously, many of these people will not be convinced that achieving greater equity justifies their having to pay more for coverage. Based on the limited data that is available, however, it does not seem likely that large numbers of people would experience major rates increases.

Not all insurers are likely to greet a merger with enthusiasm, in part because it would require them to change some of the ways they do business. For example, Cigna does not now participate in the individual market, but in a merged market, they would be required to make their products available to individuals, not just small groups.

On balance, the main disadvantages to a merger appear to be political rather than practical or conceptual. Some of these might be ameliorated by phasing in the change to across-the-board pure community rating.

A Second Three-Market Example

	A	B	C	D	E	F	G	H	I	J	K	L
CURRENT	*Enrollment*	*Total Monthly Medical Expense Per Enrollee*	Selection Effect Ratio: Medical Expense as % of Association Medical Expense	*Total Monthly Medical Costs*	*% Paid by Insurance*	Benefits Effect Ratio: % Paid by Insurance Divided by Association % Paid by Insurance	*$ Paid by Insurance*	*Monthly Insurance Premium*	*Monthly Out-of Pocket Expense*	*Total Employer/ Employee Cost per Month (Insurance Premium and Out-of-Pocket)*	*Total of Insurance Premium and Out of Pocket*	*Ratio of New Total Cost to Old Total Cost*
Individual	8,964	$500	152%	$4,482,000	49%	52%	$2,216,205	$247	$253	$500	$4,482,000	100%
Small Group	19,681	$400	121%	$7,872,400	92%	96%	$7,275,164	$370	$30	$400	$7,872,400	100%
Association	95,666	$330	100%	$31,569,780	96%	100%	$30,288,675	$317	$13	$330	$31,569,780	100%
Total	124,311	$353		$43,924,180	91%		$39,780,045	$320	$33	$353	$43,924,180	100%
SHARED EXPERIENCE (COMMUNITY RATING), CURRENT BENEFITS												
Individual	8,964	$500	152%	$4,482,000	49%	52%	$1,541,215	$172	$253	$425	$3,807,010	85%
Small Group	19,681	$400	121%	$7,872,400	92%	96%	$6,324,208	$321	$30	$352	$6,921,444	88%
Association	95,666	$330	100%	$31,569,780	96%	100%	$31,914,621	$334	$13	$347	$33,195,726	105%
	124,311	$353		$43,924,180	91%		$39,780,045	$320	$33	$353	$43,924,180	100%
SHARED EXPERIENCE (COMMUNITY RATING), BEST BENEFITS												
Individual	8,964	$500	152%	$4,482,000	96%	100%	$3,652,521	$339	$17	$356	$3,193,307	71%
Small Group	19,681	$400	121%	$7,872,400	96%	100%	$6,640,571	$339	$14	$353	$6,952,780	88%
Association	95,666	$330	100%	$31,569,780	96%	100%	$31,848,640	$339	$14	$353	$33,778,093	107%
	124,311	$353		$43,924,180	96%	100%	$42,141,732	$339	$14	$353	$43,924,180	100%

Association Example

CURRENT (SAME BENEFITS ASSUMED)												
Association 1	10,200	$470	142%	$4,794,000	90%	100%	$4,314,600	$423	$47	$470	$4,794,000	100%
Association 2	75,000	$354	107%	$26,550,000	90%	100%	$23,895,000	$319	$35	$354	$26,550,000	100%
Association 3	10,466	$250	76%	$2,616,500	90%	100%	$2,354,850	$225	$25	$250	$2,616,500	100%
Total	95,666	$355		$33,960,500	90%	100%	$30,564,450	$319	$35	$355	$33,960,500	100%
SHARED EXPERIENCE (COMMUNITY RATING), BEST BENEFITS												
Association 1	10,200	$470	142%	$4,794,000	90%	100%	$4,314,600	$339	$47	$386	$3,937,225	82%
Association 2	75,000	$354	107%	$26,550,000	90%	100%	$23,895,000	$339	$35	$374	$28,080,183	106%
Association 3	10,466	$250	76%	$2,616,500	90%	100%	$2,354,850	$339	$25	$364	$3,809,650	146%
Total	95,666	$355		$33,960,500	90%	100%	$30,564,450	$339	$16	$355	$35,827,057	100%

Note: This analysis assumes that reducing the out-of-pocket liability of insured people causes no increase in their utilization of services, which is a useful assumption for this analysis but is probably not realistic.